

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN72AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2008
NAME OF PROVIDER OR SUPPLIER AQUARIUS GRP CARE HOME INC #1		STREET ADDRESS, CITY, STATE, ZIP CODE 590 STEWART ST RENO, NV 89502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 9/17/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was three. Three resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 870 SS=C	449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Administration NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. This Regulation is not met as evidenced by:	Y 870		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN72AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2008
NAME OF PROVIDER OR SUPPLIER AQUARIUS GRP CARE HOME INC #1		STREET ADDRESS, CITY, STATE, ZIP CODE 590 STEWART ST RENO, NV 89502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 870	Continued From page 1 Based on record review on 9/17/08, the facility did not ensure 2 of 3 resident medication regimens were reviewed every six months. Findings include: The file for Resident #1 contained medication reviews completed in May and November 2007. The next medication review was not completed until September 2008, ten months later. The file for Resident #2 contained medication reviews completed in August 2007 and April 2008, nine months apart. Severity: 1 Scope: 3	Y 870		
Y 936 SS=E	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 9/17/08, the facility did not ensure 1 of 3 residents met tuberculosis (TB) testing requirements. Findings include:	Y 936		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN72AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2008
NAME OF PROVIDER OR SUPPLIER AQUARIUS GRP CARE HOME INC #1			STREET ADDRESS, CITY, STATE, ZIP CODE 590 STEWART ST RENO, NV 89502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 936	Continued From page 2 The file for Resident #2 contained evidence of an annual one-step TB test completed on 11/27/06 and a one-step TB test completed on 3/31/08. There was no evidence of an annual TB test completed in 2007. The resident requires an additional one-step TB test to meet the two-step TB test requirement. The additional one-step test can be combined with the 3/31/08 test and qualify as a two-step test. Repeat deficiency from the annual State Licensure survey on 9/4/07. Severity: 2 Scope: 2	Y 936			
Y 939 SS=C	449.2749(1)(g)(2) Resident File NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living.	Y 939			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN72AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2008
NAME OF PROVIDER OR SUPPLIER AQUARIUS GRP CARE HOME INC #1		STREET ADDRESS, CITY, STATE, ZIP CODE 590 STEWART ST RENO, NV 89502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 939	Continued From page 3 This Regulation is not met as evidenced by: Based on record review on 9/17/08, the facility did not ensure 2 of 3 residents had evidence of annual activities of daily living (ADL) assessments. Findings include: The files for Residents #1 and #3 did not contain evidence of annual ADL assessments for 2007 and 2008. Severity: 1 Scope: 3	Y 939		
Y 944 SS=A	449.2749(2) Resident File / Discharge NAC 449.2749 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. This Regulation is not met as evidenced by:	Y 944		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN72AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2008
NAME OF PROVIDER OR SUPPLIER AQUARIUS GRP CARE HOME INC #1			STREET ADDRESS, CITY, STATE, ZIP CODE 590 STEWART ST RENO, NV 89502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 944	<p>Continued From page 4</p> <p>Based on record review and interview on 9/17/08, the facility did not ensure the file for a discharged resident contained information concerning the discharge.</p> <p>Findings include:</p> <p>The file for Resident #4 did not contain information concerning his discharge from the facility. The caregiver reported the resident passed away.</p> <p>Severity: 1 Scope: 1</p>	Y 944			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.